

SERFF Tracking Number:	AOIC-125528891	State:	Arkansas
First Filing Company:	Auto-Owners Insurance Company, ...	State Tracking Number:	EFT \$50
Company Tracking Number:	GAR-AR-99-03/07/2008-89957		
TOI:	20.0 Commercial Auto	Sub-TOI:	20.0002 Garage
Product Name:	Garage Liability		
Project Name/Number:	GAR/89957		

## Filing at a Glance

Companies: Auto-Owners Insurance Company, Owners Insurance Company

Product Name: Garage Liability

SERFF Tr Num: AOIC-125528891

State: Arkansas

TOI: 20.0 Commercial Auto

SERFF Status: Closed

State Tr Num: EFT \$50

Sub-TOI: 20.0002 Garage

Co Tr Num: GAR-AR-99-03/07/2008-89957

State Status: Fees verified and received

Filing Type: Form

Co Status: In Progress

Reviewer(s): Betty Montesi, Llyweyia Rawlins, Brittany Yielding

Authors: Claudia Stewart, Sarah Franklin

Disposition Date: 03/14/2008

Date Submitted: 03/07/2008

Disposition Status: Approved

Effective Date Requested (New): On Approval

Effective Date (New): 04/06/2008

Effective Date Requested (Renewal): On Approval

Effective Date (Renewal): 04/06/2008

State Filing Description:

## General Information

Project Name: GAR

Status of Filing in Domicile: Authorized

Project Number: 89957

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 03/14/2008

State Status Changed: 03/13/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

FORM FILING: 89957 (09-07) - Employee Benefits Liability Insurance

Form Attaches To:

Garage Liability Coverage

Use: Provides employee benefits liability

Revisions to the form include:

<i>SERFF Tracking Number:</i>	<i>AOIC-125528891</i>	<i>State:</i>	<i>Arkansas</i>
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Modifying to make more similar to ISO form and to make coverage apply to the policy term.  
 Submitted for your approval is the above-referenced form. We desire to use this form with  
 policies effective on or after April 06, 2008. Forms are submitted in final printed copy.

If you have any questions, please feel free to contact one of the following:

Manager:

JENNIFER HAMILTON, ASSISTANT MANAGER  
 GARAGE LIABILITY AND DEALER'S BLANKET  
 HAMILTON.JENNIFER@AOINS.COM (emails without attachments)  
 commlinesund@aoins.net (emails with attachments)  
 517-391-1026

Underwriter:

TRACY NICHOLS  
 NICHOLS.TRACY@AOINS.COM

## Company and Contact

### Filing Contact Information

Jennifer Hamilton, Assistant Manager	hamilton.jennifer@aoins.com
P. O. Box 30660	(800) 346-0346 [Phone]
Lansing, MI 48909-8160	(517) 391-1903[FAX]

### Filing Company Information

Auto-Owners Insurance Company	CoCode: 18988	State of Domicile: Michigan
P.O. Box 30660	Group Code: 280	Company Type: PC
Lansing, MI 48909-8160	Group Name: Auto-Owners Ins Group	State ID Number:
(800) 346-0346 ext. [Phone]	FEIN Number: 38-0315280	

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Owners Insurance Company	CoCode: 32700	State of Domicile: Ohio
P.O. Box 30660	Group Code: 280	Company Type: PC
Lansing, MI 48909-8160	Group Name: Auto-Owners Ins Group	State ID Number:
(800) 346-0346 ext. [Phone]	FEIN Number: 34-1172650	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Auto-Owners Insurance Company	\$50.00	03/07/2008	18448994
Owners Insurance Company	\$0.00	03/07/2008	

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Llyweyia Rawlins	03/14/2008	03/14/2008

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Uniform Transmittal Document - Property & Casualty	Supporting Document	Sarah Franklin	03/13/2008	03/13/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Missing Form	Note To Reviewer	Sarah Franklin	03/13/2008	03/13/2008
Missing Form	Note To Filer	Llyweyia Rawlins	03/13/2008	03/13/2008

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## Disposition

Disposition Date: 03/14/2008  
Effective Date (New): 04/06/2008  
Effective Date (Renewal): 04/06/2008  
Status: Approved  
Comment:

Rate data does NOT apply to filing.

### Overall Rate Information for Multiple Company Filings

Overall Percentage Rate Indicated For This Filing	0.000%
Overall Percentage Rate Impact For This Filing	0.000%
Effect of Rate Filing-Written Premium Change For This Program	\$0
Effect of Rate Filing - Number of Policyholders Affected	0

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Uniform Transmittal Document-Property & Casualty	Approved	Yes
<b>Supporting Document</b>	Uniform Transmittal Document - Property & Casualty	Approved	Yes
<b>Form</b>	Employee Benefits Liability Insurance	Approved	Yes

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#### **Amendment Letter**

Amendment Date:

Submitted Date: 03/13/2008

#### **Comments:**

I have uploaded the correct Uniform Transmittal forms.

#### **Changed Items:**

#### **Supporting Document Schedule Item Changes:**

#### **User Added -Name: Uniform Transmittal Document - Property & Casualty**

Comment:

89957 NAIC 1.pdf

89957 NAIC 2.pdf

89957 NAIC 3.pdf

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**Note To Reviewer**

**Created By:**

Sarah Franklin on 03/13/2008 11:42 AM

**Subject:**

Missing Form

**Comments:**

Actually we are only filing 89957 Employee Benefits Liability Insurance. I'am sorry for the confusion. I will amend the filing and upload new supporting documentation.



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**Note To Filer**

**Created By:**

Llyweyia Rawlins on 03/13/2008 10:41 AM

**Subject:**

Missing Form

**Comments:**

Hello Jennifer

In reviewing your filing form list, I've noticed that I am missing form 89415 (11-07) Property Dam./Product Liab. Ded.  
Once I receive this form I can finish reviewing this filing.

Thank You

Llyweyia Rawlins

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## Form Schedule

Review	Form Name	Form #	Edition	Form Type	Action	Action Specific	Readability	Attachment
Status			Date			Data		
Approved	Employee Benefits Liability Insurance	89957	09-07	Endorseme nt/Amendm ent/Condi tions	Replaced	Replaced Form #:0.00 89957 Previous Filing #:		89957 _9- 07_ a.pdf

## EMPLOYEE BENEFITS LIABILITY INSURANCE

### Garage Liability

It is agreed:

**A. SECTION I - DEFINITIONS** is amended as follows as it applies to this endorsement only:

**a.** The definitions **F. Employee** and **BB. Suit** are deleted and replaced by the following:

**F. Employee** means a person actively employed, formerly employed, on leave of absence or disabled, or retired. **Employee** includes a **leased worker**. **Employee** does not include a **temporary worker**.

**BB. Suit** means a civil proceeding in which damages because of an act, error or omission to which this insurance applies are alleged. **Suit** includes:

- a.** An arbitration proceeding in which such damages are claimed and to which the **insured** must submit or does submit with **our** consent; or
- b.** Any other alternative dispute resolution proceeding in which such damages are claimed and to which the **insured** submits with **our** consent.

**b.** The following definitions are added:

**(1) Administration** means:

- a)** Providing information to **employees**, including their dependents and beneficiaries, with respect to eligibility for or scope of **employee benefit programs**;
- b)** Handling records in connection with the **employee benefit program**; or
- c)** Effecting, continuing or terminating any **employees** participation in any benefit included in the **employee benefit program**.

However, **administration** does not include handling payroll deductions.

**(2) Cafeteria plans** means plans authorized by applicable law to allow **employees** to elect to pay for certain benefits with pre-tax dollars.

**(3) Claim** means any demand, or **suit**, made by an **employee** or an **employee's** dependents and beneficiaries, for damages as the result of an act, error or omission.

**(4) Employee benefit program** means a program providing some or all of the following benefits to **employees**, whether provided through a **cafeteria plan** or otherwise:

**a)** Group life insurance, group accident or health insurance, dental, vision and hearing plans, and flexible spending accounts, provided that no one other than an **employee** may subscribe to such benefits and such benefits are made generally available to those **employees** who satisfy the plan's eligibility requirements;

**b)** Profit sharing plans, employee savings plans, employee stock ownership plans, pension plans and stock subscription plans, provided that no one other than an **employee** may subscribe to such benefits and such benefits are made generally available to all **employees** who are eligible under the plan for such benefits;

**c)** Unemployment insurance, social security benefits, workers compensation and disability benefits;

- d) Vacation plans, including buy and sell programs; leave of absence programs, including military, maternity, family, and civil leave; tuition assistance plans; transportation and health club subsidies; and
- e) Any other similar benefits designated in the Declarations or by endorsement.

**B.** Under **SECTION II - COVERAGE**, the following coverage is added:

**EMPLOYEE BENEFITS LIABILITY INSURANCE**

**1. COVERAGE**

a. We will pay those sums the **insured** becomes legally obligated to pay as damages to:

- (1) An **employee**, their beneficiaries or legal representative; or
- (2) A former **employee**, their beneficiaries or legal representative

because of any act, error or omission:

- (1) Of the **insured**; or
- (2) Of any other person for whose acts the **insured** is legally liable

to which this insurance applies.

We will have the right and duty to defend the **insured** against any **suit** seeking those damages. We may, at **our** discretion, investigate any report of an act, error or omission and settle any **claim** or **suit** that may result. But:

- (1) The amount we will pay for damages is limited as described in paragraph **E.** of this endorsement; and
- (2) **Our** right and duty to defend ends when we have used up the applicable limit of insurance for this coverage in the payment of judgments or settlements.

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments.

b. This insurance applies to damages only if:

- (1) The act, error or omission is negligently committed in the **administration of your employee benefit program**;
- (2) The act, error or omission takes place in the **coverage territory**; and
- (3) The act, error or omission occurs during the policy period. All **claims** for damages made by an **employee**, former **employee**, or their beneficiaries or legal representative because of more than one act, error or omission, will be deemed to have been made at the time the first act, error or omission occurred.

**2. EXCLUSIONS**

The coverage provided by this endorsement does not apply to:

- a. Damages arising out of any intentional, dishonest, fraudulent, criminal or malicious act, error or omission, committed by any **insured**, including the willful or reckless violation of any statute.
- b. **Bodily injury, property damage, personal injury or advertising injury.**
- c. Damages arising out of failure of performance of a contract by any insurer, including failure of an **employee benefit program**.
- d. Damages arising out of an insufficiency of funds to meet any obligations under any plan included in the **employee benefit program**.
- e. Any **claim** based upon:
  - (1) Failure of any investment to perform;

- (2) Errors in providing information on past performance of investment vehicles; or
  - (3) Advice given to any person with respect to that person's decision to participate in any plan included in the **employee benefit program**.
- f. Any **claim** arising out of **your** failure to comply with the mandatory provisions of any workers compensation, unemployment compensation insurance, social security or disability benefits law or any similar law.
- g. Damages for which any **insured** is liable because of liability imposed on a fiduciary by the Employment Retirement Income Security Act of 1974, as now or hereafter amended, or by any similar federal, state or local laws.
- h. Any **claim** for benefits to the extent that such benefits are available, with reasonable effort and cooperation of the **insured**, from the applicable funds accrued or other collectible insurance.
- i. Taxes, fines or penalties, including those imposed under the Internal Revenue Code or any similar state or local law.
- j. Damages arising out of any actual or alleged:
- (1) Wrongful dismissal, discharge or termination (either actual or constructive), including breach of an implied contract;
  - (2) Harassment of any kind;
  - (3) Discrimination of any type;
  - (4) Retaliatory acts alleged to be in response to the actual or attempted exercise by an **employee** or former **employee** of any right that such **employee** or former **employee** has under the law;
  - (5) Employment-related libel, slander, humiliation, mental anguish, infliction of emotional distress, defamation or invasion of privacy;
  - (6) Wrongful failure to employ or promote;
  - (7) Wrongful deprivation of career opportunity, wrongful demotion or negligent **employee** evaluation, including the giving of negative or defamatory statements in connection with an **employee** reference;
  - (8) Wrongful imposition of discipline; and
  - (9) Violation of an individual's civil rights relating to any of the above.
- k. Damages for any related acts, errors or omissions if the first act, error or omission occurred prior to the policy period. Acts, errors or omissions are deemed to be related if they involve the same **employees** or former **employees** regardless of the number of **employees** or former **employees** or the number of acts, errors or omissions committed.
- C. For the purposes of the coverage provided by this endorsement only:
- 1. All references to **SUPPLEMENTARY PAYMENTS - COVERAGES A AND B** are replaced by **SUPPLEMENTARY PAYMENTS - COVERAGES A, B and EMPLOYEE BENEFITS LIABILITY**.
  - 2. Paragraph 2. of the Supplementary Payments provision does not apply to the coverage provided by this endorsement.
- D. For the purposes of the coverage provided by this endorsement only, **SECTION III - WHO IS AN INSURED** is deleted and replaced by the following:
- SECTION III - WHO IS AN INSURED**
- 1. If **you** are designated in the Declarations as:
    - a. An individual, you and **your** spouse are **insureds**, but only with respect to the conduct of a business of which **you** are the sole owner.
    - b. A partnership or joint venture, **you** are an **insured**. **Your** members, **your** partners, and their spouses are also **insureds**, but

only with respect to the conduct of **your** business.

- c. A limited liability company, **you** are an **insured**. Your members are also **insureds**, but only with respect to the conduct of **your** business. **Your** managers are **insureds**, but only with respect to their duties as **your** managers.
- d. An organization other than a partnership, joint venture or limited liability company, **you** are an **insured**. **Your executive officers** and directors are **insureds**, but only with respect to their duties as **your** officers or directors. **Your** stockholders are also **insureds**, but only with respect to their liability as stockholders.
- e. A trust, **you** are an **insured**. **Your** trustees are also **insureds**, but only with respect to their duties as trustees.

2. Each of the following is also an **insured**:

- a. Each of **your employees** who is or was authorized to administer **your employee benefit program**.
- b. Any persons, organizations or **employees** having proper temporary authorization to administer **your employee benefit program** if **you** die, but only until legal representation is appointed.
- c. **Your** legal representative if **you** die, but only with respect to duties as such. That representative will have all **your** rights and duties under this endorsement.

3. Any organization **you** newly acquire or form, other than a partnership, joint venture or limited liability company, and over which **you** maintain ownership or majority interest, will qualify as a Named **Insured** if no other similar insurance applies to that organization. However:

- a. Coverage under this provision is afforded only until the 90th day after **you** acquire or form the organization or the end of the policy period, whichever is earlier.
- b. Coverage under this provision does not apply to any act, error or omission that was committed before **you** acquired or formed the organization.

E. For the purposes of the coverage provided by this endorsement only, the following provision is added to **SECTION IV - LIMITS OF INSURANCE**:

<b>EMPLOYEE INSURANCE</b>	<b>BENEFITS</b>	<b>LIABILITY</b>
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1. The Limits of Insurance shown in the Declarations and rules below fix the most **we** will pay regardless of the number of:

- a. **Insureds**;
- b. **Claims** made or **suits** brought;
- c. Persons or organizations making claims or bringing **suits**;
- d. Acts, errors or omissions; or
- e. Benefits included in **your employee benefit program**.

2. The Employee Benefits Liability Aggregate Limit is the most **we** will pay for all damages during any one policy period because of acts, errors or omissions negligently committed in the **administration of your employee benefit program**, subject to paragraph 3. immediately below.

3. Subject to the Employee Benefits Liability Aggregate Limit, the Employee Benefits Liability Each Employee Limit is the most **we** will pay for all damages sustained by any one **employee**, including damages sustained by such **employee's** dependents and beneficiaries, as a result of:

- a. An act, error or omission; or
- b. A series of related acts, errors or omissions

negligently committed in the **administration of your employee benefit program**.

However, the amount paid under this endorsement shall not exceed, and will be subject to, the limits and restrictions that apply to the payment of benefits in any plan included in the **employee benefit program**.

The Limits of Insurance of this endorsement apply separately to each consecutive annual period of less than 12 months starting with the beginning of the policy period shown in the Declarations of the policy to

which this endorsement is attached, unless the policy period is extended after issuance for an additional period of less than 12 months. In that case, the additional period will be deemed part of the last preceding period for purposes of determining the Limits Of Insurance.

**F.** For the purposes of the coverage provided by this endorsement only, the following provision is added to **SECTION V - DEDUCTIBLE**.

1. **Our** obligation to pay damages on behalf of the **insured** applies only to the amount of damages in excess of \$1,000 as applicable to Each Employee. The Limits of Insurance shall not be reduced by the amount of this deductible.
2. The \$1,000 deductible applies to all damages sustained by any one **employee**, including such **employee's** dependents and beneficiaries, because of all acts, errors or omissions to which this insurance applies.
3. The terms of this insurance, including those with respect to:
  - a. **Our** right and duty to defend any **suits** seeking those damages; and
  - b. **Your** duties, and the duties of any other involved **insured**, in the event of an act, error or omission, or **claim**apply irrespective of the application of the deductible amount.
4. **We** may pay all of the deductible amount to effect settlement of any **claim** or **suit** and, upon notification of the action taken, **you** shall promptly reimburse **us** for the deductible amount **we** have paid.

**G.** For the purposes of the coverage provided by this endorsement only, **SECTION VI - WHAT YOU MUST DO AFTER AN ACCIDENT, OCCURRENCE OR LOSS** is deleted and replaced by the following:

**SECTION VI - WHAT YOU MUST DO IN THE EVENT OF AN ACT, ERROR OR OMISSION, OR CLAIM OR SUIT**

- A.** **You** must see to it that **we** are notified as soon as practicable of an act, error or omission which may result in a **claim**. To the extent possible, notice should include:

1. What the act, error or omission was and when it occurred; and
2. The names and addresses of anyone who may suffer damages as a result of the act, error or omission.

**B.** If a **claim** or **suit** is brought against any **insured**, **you** must:

1. Immediately record the specifics of the **claim** or **suit** and the date received; and
2. Notify **us** as soon as practicable.

**You** must see to it that **we** receive written notice of any **claim** or **suit** as soon as practicable.

**C.** **You** and any other involved **insured** must:

1. Immediately send **us** copies of any demands, notices, summonses or legal papers received in connection with the **claim** or **suit**;
2. Authorize **us** to obtain records and other information;
3. Cooperate with **us** in the investigation or settlement of the **claim** or defense against the **suit**; and
4. Assist **us**, upon **our** request, in the enforcement of any right against any person or organization which may be liable to the **insured** because of an act, error or omission to which this insurance may also apply.

**D.** No **insured** will, except at that **insured's** own cost, voluntarily make a payment, assume any obligation or incur any expense without **our** written consent.

**H.** For the purposes of the coverage provided by this endorsement only, under **SECTION VII - GENERAL CONDITIONS, E. OTHER INSURANCE** is deleted and replaced by the following:

**E. OTHER INSURANCE**

This insurance is primary. If any other insurance is also primary, then **we** will share that other insurance by the method described below.

If all other insurance permits contribution by equal shares, **we** will follow this method also.

Under this approach each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.

If any other insurance does not permit contribution by equal shares, **we** will contribute by limits. Under this method, each insurer's

share is based on the ratio of its applicable limits of insurance to the total applicable limits of insurance of all insurers.

All other policy terms and conditions apply.



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## **Rate Information**

Rate data does NOT apply to filing.

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Project Name/Number:	GAR/89957		

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Uniform Transmittal Document-Property & Casualty	<b>Review Status:</b>	Approved	03/14/2008
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### Comments:

### Attachments:

89957 NAIC 2.pdf  
89957 NAIC 3.pdf  
89957 NAIC 1.pdf

<b>Satisfied -Name:</b>	Uniform Transmittal Document -Property & Casualty	<b>Review Status:</b>	Approved	03/14/2008
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### Comments:

### Attachments:

89957 NAIC 1.pdf  
89957 NAIC 2.pdf  
89957 NAIC 3.pdf

## Property and Casualty Transmittal Document-

<b>20.</b>	<b>This filing transmittal is part of Company Tracking #</b>	GARAR20307200889957
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<b>21.</b>	<b>Filing Description</b> [This area should be similar to the body of a cover letter and is free-form text]
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FORM FILING: See Attached List

Forms Attach To:

Garage Liability Coverage

Submitted for your approval is the attached list of forms. We desire to use these forms with policies effective on or after April 06, 2008. Forms are submitted in final printed copy.

If you have any questions, please feel free to contact one of the following:

**Manager:**

JENNIFER HAMILTON, ASSISTANT MANAGER

GARAGE LIABILITY AND DEALER'S BLANKET

HAMILTON.JENNIFER@AOINS.COM (emails without attachments)

commmlinesund@aoins.net (emails with attachments)

517-391-1026

Ext.

**Underwriter:**

TRACY NICHOLS

NICHOLS.TRACY@AOINS.COM

<b>22.</b>	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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**Check #:**

**Amount:**

**Calculation:**

**Refer to each state's checklist for additional state specific requirements or instructions on calculating fees**

\*\*\*Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

**FORM FILING SCHEDULE**

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing.)

<b>1.</b>	<b>This filing transmittal is part of Company Tracking #</b>	GARGA20307200889957			
<b>2.</b>	<b>This filing corresponds to rate/rule filing number</b> (Company tracking number of rate/rule filing, if applicable)				
<b>3.</b>	<b>Form Name Description/Synopsis</b>	<b>Form # Include edition date</b>	<b>Replacement Or withdrawn?</b>	<b>If replacement, give form # it replaces</b>	<b>Previous State Filing Number, if required by state</b>
<b>1</b>	Employee Benefits Liability Insurance	89957 (09-07)	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	89957 (09-06)	
<b>2</b>	Property Damage / Products Liability Deductible	89415 (11-07)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	( )	

PC FFS-1

GA-2

## Property &amp; Casualty Transmittal Document (Revised 1/1/08)

<b>1. Reserved for Insurance Dept. Use Only</b>	<b>2. Insurance Department Use Only</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2">a. Date the filing is received:</td></tr> <tr><td colspan="2">b. Analyst:</td></tr> <tr><td colspan="2">c. Disposition:</td></tr> <tr><td colspan="2">d. Date of disposition of the filing:</td></tr> <tr><td colspan="2">e. Effective date of filing:</td></tr> <tr> <td style="width: 50%;">New Business</td> <td style="width: 50%;"></td> </tr> <tr> <td>Renewal Business</td> <td></td> </tr> <tr><td colspan="2">f. State Filing #:</td></tr> <tr><td colspan="2">g. SERFF Filing #:</td></tr> <tr><td colspan="2">h. Subject Codes</td></tr> </table>	a. Date the filing is received:		b. Analyst:		c. Disposition:		d. Date of disposition of the filing:		e. Effective date of filing:		New Business		Renewal Business		f. State Filing #:		g. SERFF Filing #:		h. Subject Codes	
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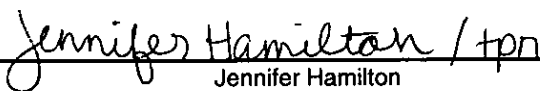
<b>3. Group Name</b>	<b>Group NAIC #</b>
AUTO-OWNERS INSURANCE GROUP COMPANY	280

4. Company Name(s)	Domicile	NAIC #	FEIN #
AUTO-OWNERS INSURANCE COMPANY	Michigan	280-18988	38-0315280
OWNERS INSURANCE COMPANY	Ohio	280-32700	34-1172650

**5. Company Tracking Number** GARAR20307200889957

Contact Info for Filer(s) or Corporate Officer(s) [include toll-free number]

6. Name and address	Telephone #s	FAX #	E-mail
Jennifer Hamilton, Assistant Manager P.O. Box 30660 Lansing, MI 48909-8160	517-391-1026 800-346-0346 Ext.	(517) 391-1903	HAMILTON.JENNIFER@AOINS.COM

7. Signature of authorized filer	
8. Please print name of authorized filer	Jennifer Hamilton

Filing Information (see general instructions for descriptions of these fields)

9. Type of Insurance (TOI)	20.0000 Commercial Auto
10. Sub-Type of Insurance (Sub-TOI)	20.0002 Garage
11. State Specific Product code(s) (if applicable) [See State Specific Requirements]	
12. Company Program Title (Marketing Title)	Garage Liability
13. Filing Type	FORM
14. Effective Dates(s) Requested	April 06, 2008
15. Reference Filing?	No
16. Reference Organization (if applicable)	
17. Reference Organization #	
18. Company's Date of Filing	March 07, 2008
19. Status of filing in domicile	Michigan- Exempt

## Property &amp; Casualty Transmittal Document (Revised 1/1/08)

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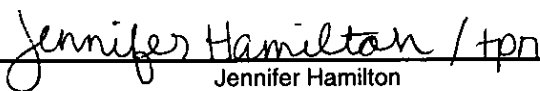
<b>3. Group Name</b>	<b>Group NAIC #</b>
AUTO-OWNERS INSURANCE GROUP COMPANY	280

4. Company Name(s)	Domicile	NAIC #	FEIN #
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OWNERS INSURANCE COMPANY	Ohio	280-32700	34-1172650

**5. Company Tracking Number** GARAR20307200889957

Contact Info for Filer(s) or Corporate Officer(s) [include toll-free number]

6. Name and address	Telephone #s	FAX #	E-mail
Jennifer Hamilton, Assistant Manager P.O. Box 30660 Lansing, MI 48909-8160	517-391-1026 800-346-0346 Ext.	(517) 391-1903	HAMILTON.JENNIFER@AOINS.COM

7. Signature of authorized filer	 Jennifer Hamilton
8. Please print name of authorized filer	Jennifer Hamilton

Filing Information (see general instructions for descriptions of these fields)

9. Type of Insurance (TOI)	20.0000 Commercial Auto
10. Sub-Type of Insurance (Sub-TOI)	20.0002 Garage
11. State Specific Product code(s) (if applicable) [See State Specific Requirements]	
12. Company Program Title (Marketing Title)	Garage Liability
13. Filing Type	FORM
14. Effective Dates(s) Requested	April 06, 2008
15. Reference Filing?	No
16. Reference Organization (if applicable)	
17. Reference Organization #	
18. Company's Date of Filing	March 07, 2008
19. Status of filing in domicile	Michigan- Exempt

## Property and Casualty Transmittal Document-

20.	<b>This filing transmittal is part of Company Tracking #</b> GARAR20307200889957
21.	<b>Filing Description</b> [This area should be similar to the body of a cover letter and is free-form text]  <b>FORM FILING:</b> 89957 (09-07) - Employee Benefits Liability Insurance  Form Attaches To: Garage Liability Coverage  <b>Use:</b> Provides employee benefits liability  <b>Revisions to the form include:</b> Modifying to make more similar to ISO form and to make coverage apply to the policy term.  Submitted for your approval is the above-referenced form. We desire to use this form with policies effective on or after April 06, 2008. Forms are submitted in final printed copy.  If you have any questions, please feel free to contact one of the following:  <b>Manager:</b> JENNIFER HAMILTON, ASSISTANT MANAGER GARAGE LIABILITY AND DEALER'S BLANKET HAMILTON.JENNIFER@AOINS.COM (emails without attachments) commmlinesund@aoins.net (emails with attachments) 517-391-1026  <b>Underwriter:</b> TRACY NICHOLS NICHOLS.TRACY@AOINS.COM

22.	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
<b>Check #:</b> <b>Amount:</b> <b>Calculation:</b> <b>Refer to each state's checklist for additional state specific requirements or instructions on calculating fees</b>	

\*\*\*Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

# FORM FILING SCHEDULE

Ed. 01/05

This form must be provided ONLY when making a filing that includes forms

(Do NOT refer to the body of the filing for the forms listing.)

This page applies to the following state(s) **Arkansas**

1.	This filing transmittal is part of Company Tracking #	
2.	This filing corresponds to rate/rule filing number	

3.	Form Name/ Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous State Filing Number, if required by state
01	Employee Benefits Liability Insurance	89957 (09-07)	<input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither	89957 (09-06)	
02			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
03			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
04			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
05			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
06			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
07			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
08			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		
09			<input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn <input type="checkbox"/> Neither		

To be complete, a form filing must include the following:

1. A completed Form Filing Schedule Document (PC FFS-1) **(Do not refer to the body of the filing for the forms listing.)** and,
2. A completed Property and Casualty Transmittal Document (PC TD-1), and
3. One copy of each form to be reviewed for the reviewer's records, and
4. One copy of any other components/exhibits submitted with the filing, and
5. The appropriate state Review Requirements, if required, and
6. The appropriate filing fees, if required, and
7. A postage-paid, self-addressed envelope large enough to accommodate the return.
8. You should refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)